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Small Business and Access to Health Insurers, Particularly HMOs

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EXECUTIVE SUMMARY

The project goal was to provide information on health insurance coverage, types, and costs, offered to different categories of small firms. The project focused special attention on HMO offerings to small firms. A document review of small employer health insurance legislation in all fifty United States was conducted. HMO's from ten selected states were surveyed. How health care coverage and cost by small firms is changing was addressed through focus group data collection and analysis.

Lack of coverage for employees of small employers is important for two reasons. First, about 37% of working Americans are employed by small businesses of ninety-nine or fewer workers. Secondly, many recent efforts to reform the health insurance market have included reforms in the small employer market. It is possible that these efforts may not have achieved the reforms in the small employer market or may have worsened the situation.

The focus of reform has been two fold, to control costs and improve access. The key strategy to control cost has been to strengthen managed care initiatives. The thrust to improve access has focused on employers and their coverage of workers, specifically on small businesses, since 51% of the uninsured worked for small businesses employing 99 or fewer workers (Morrisey et al. 1994). The increasing emphasis of health care reform on the small business sector reflects recent business trends in the United States. Twelve percent (12%) of workers in firms offering health insurance coverage are not eligible for coverage. Of those who are eligible, sixteen percent (16%) of workers opted not to take the coverage (Gable et al. 1999). Between 1988 and 1995, the US economy produced 12 million new jobs, of which eight to nine million were among firms that employed 499 or fewer workers (Gable et al. 1997). During this period

the overall proportion of workers in firms offering employment-based insurance coverage fell from 76.2% to 73.2% (Cooper et al. 1997). Several states undertook major policy initiatives to promote health insurance coverage by small employers, including legislation mandating specific types of benefits, facilitating purchasing alliances, and enacting small-group market reforms related to insurance rating and medical underwriting (Cooper et al. 1997; Gable et al. 1997; Helms et al. 1992).

More recently, federal legislation has superseded state policy initiatives to address access to health insurance for the small employer market. The effect of the proliferation of health reform legislation is mixed. The comprehensive review of health insurance regulations across the states did not uncover any significant patterns that could be associated with the number of uninsured in each state. The mixed results suggest a different approach to determine the impact of legislation on access to health insurance for small employers. There are a number of major factors that confound the findings in this state document review, such as individual state policies and laws concerning Medicaid coverage and eligibility, Children's Health Insurance Plan (CHIP) regulations, and welfare to work programs. In addition, each state has a unique economy, many of which are booming at this time (low unemployment, lack of qualified employees in many sectors, stable tax base), resulting in employers= willingness to provide more extensive employee benefits. As seen in the Robert Wood Johnson Foundation's, Community Snapshots Project through the Center for Studying Health System Change, communities vary tremendously in their health care markets. And the health care markets have a complex and intertwining relationship with both the small and large members of the business community. Each community, or state, has unique catalysts that impact the dynamics of the health insurance

industry and other industries. These markets also operate in the context of widely varying social and political environments. These complexities mask any discernable relationships between the numbers of uninsured and state regulations.

One approach to standardizing the various health insurance markets across states, is to have more and stronger Federal legislation as related to the small business insurance market. Of particular interest are those areas where states have tremendous latitude in setting their own regulations, such as establishing a national reinsurance guidelines for small groups, and establishing purchasing pools at a state level and providing support of the administration of those pools.

HMOs in ten selected states were surveyed. HMOs were asked about specific features and options of their three most popular plans in the small business sector. Of the most popular HMO plans in the small business sector, 68% (34 out of 50 plans) had specifically assigned primary care physicians for members, 78% (39) had their primary care physicians function as gatekeepers to control service utilization, 44% (22) paid their physicians/practices on a capitated per-diem basis, and 72% of the plans (36) paid physicians/practices on a contracted (discounted fee-for- service) basis, although most of these were specialists. Thirteen (13) out of 20 HMOs required at least 75% employee participation to enroll a small business in a health plan, and 13 out of 20 required a minimum employer contribution of 50% to the employee premium.

When asked specifically about preventive services, 92% (46 out of 50) of the plans required a minimum or no co-pay for immunizations, 86% (43 out of 50) offered free or nominal co-pay mammography services, 48% (24) had free or nominal co-pay mammography services. 69% (31) offered free or nominal co-pay prenatal care services, 60% (30) offered free or nominal

co-pay childhood immunizations. Ninety-four percent of the plans (47 out of 50) offered disease prevention or health promotion activities to enrollees, and an equal percentage actively attempted to educate enrollees on how best to use the plan benefits.

The respondents were also asked a series of questions on their perspective of the issues concerning small employers and the small employer insurance market. They gave the following reasons why they believed small employers provide health insurance benefits to their employees: 1) need to attract and retain employees (21); 2) respond to employee demands for coverage (17); 3) the tight labor market (10); and 4) to get coverage for only the owner and family(14). Of these reasons, attracting and retaining employees was indicated as the single most important reason.

Most respondents indicated that cost was the major reason for employers not offering health insurance coverage. Most felt there are adequate choices for plans in the market, and also believe small employers are being provided adequate information about plans and options.
In response to the perceived effect of such state legislation on the small employer market, fifty percent of HMOs believe that flexibility had decreased and adversely impacted their market share. All respondents indicated increased costs, decreased affordability, and decreased real access associated with recent state and federal legislation.

Survey respondents were asked about pooled purchasing in their respective state and the degree to which they felt it was an effective mechanism for improving access to health insurance for the small employer. Nine respondents indicated the presence of pooled purchasing mechanisms for small businesses in their state, and only six thought it had been helpful for small businesses in accessing health insurance for their employees.

Significant differences between states= definition and HMOs= definition of a small

business were found. In Missouri, 75% of the respondents defined a small business as Aan employer with 1-50 employees, and 25% defined a small business as 2-99 employees, while the state of Missouri defined it as 3-25 employees. In California the HMOs defined a small business as one with less than 50 employees, although the state regulation defined it as 3-25 employees.

The HMO survey indicated that the non-renewal rate at the initiative of the HMO, (apart from reasons of non-payment of premium) was negligible, ranging from 1-22 policies in the last year for the ten states surveyed. The guaranteed renewal provisions appear to be effective in limiting involuntary terminations of small business health insurance.

Recent published research findings and the results of this study draw an emerging picture of small businesses finding it more and more difficult to obtain affordable health insurance for their workers. This is especially so for those small businesses that have less than 25 employees and have a disproportionate share of low-wage earning employees. This is occurring in spite of ongoing state and federal efforts to address this problem through legislation. Gabel et. al, (1997) found similar results even though states have been consistent in adopting regulations that limit ratings practice use. At the same time, findings indicate that low-wage earners are less likely to be eligible for health benefits and less likely to take them up (take-up rate). When they do take up health benefits, they are more likely to pay a greater share of the premium for single and family coverage and have a benefit package that requires a greater sharing of expenses in the form of higher deductibles and co-payments, as well as restricted benefits.

This project was devoted to examining the supply side of the health benefit equation. An integrated review of these findings in conjunction with the focus group findings and document review suggests that regulation at best has been only partly successful in achieving its goal, which

is consistent with earlier studies (Nichols et. al, 1998). This study has shown that discrepancies between explicit legal provisions and practice do exist, such as the definition of a small business.

Mandated benefits appear to be implemented by the HMOs, which is illustrated by universal offering of maternity and mental health benefits in line with state regulations. Other regulations such as mandates for fair marketing of low cost plans, are being implicitly breached. Built-in adverse marketing incentives mitigate against fair marketing of low cost plans, revealing an inadequacy of current forms of legislation. Further study is required to better understand this newly identified gap between legislation and implementation.

Additional research is needed to better understand the demand side of the equation. Specifically, a detailed exploration into the reasons small businesses do or do not provide a health insurance plan, specifically an HMO option is needed. In addition, several questions from the employer perspective need to be addressed: 1) What are the barriers to offering a plan to all employees, as opposed to only high-wage, full-time employees? 2) Have the laws in the different states had an impact on a small business's ability to provide a health plan to employees? 3)What do small businesses actually know about state insurance regulation? 4) What is the impact of expanding Medicaid and CHIP programs to their employees? 5) What are the reasons (barriers) for not taking up the health insurance benefit? 6) What changes are needed to enable the employee to use the health insurance benefits offered? 7) What benefit options are most desired? 8) How do employers view HMO products and services? 9) Are employees aware of expanded Medicaid and CHIP programs in their states and do they view them as a possible alternative to employer-sponsored health insurance?

PROJECT STATEMENT

The project goal was to provide information on health insurance coverage, types, and costs, offered to different categories of small firms. The project focused special attention on HMO offerings to small firms. A document review of small employer health insurance legislation in all fifty United States was conducted. HMO's from ten selected states were surveyed. How health care coverage and cost by small firms is changing was addressed through focus group data collection and analysis.

Most Americans with private health insurance have coverage through their work. This coverage occurs as a result of the individual or a family member having access to employer-sponsored health insurance. Approximately seventy-four percent (74%) of workers are employed by firms offering health insurance coverage. Unfortunately, not all employees have access to health insurance (Gable et al. 1999). Twelve percent (12%) of workers in firms offering health insurance coverage are not eligible for coverage. Of those who are eligible, sixteen percent (16%) of workers opted not to take the coverage (Gable et al. 1999). Numerous studies have documented the lack of coverage, especially for small employers. While a number of reasons for the lack of health insurance coverage have been identified, the primary reason has repeatedly been shown to be the high cost of the available insurance products.

Lack of coverage for employees of small employers is important for two reasons. First, thirty-seven pecent of working Americans are employed by small businesses of ninety-nine or fewer workers. Secondly, many recent efforts to reform the health insurance market have included reforms in the small employer market. It is possible that these efforts may not have

achieved the reforms in the small employer market or may have worsened the situation.

The study examined small businesses= access to private insurance, plan design and benefits, particularly for health maintenance organizations (HMO's). The study design involved a comprehensive documents review of health insurance legislation at the federal and state levels, a survey of managed care organizations in 10 states representing the different regions of the United States, and focus groups of small employers. This study builds on existing literature and will provide trend data covering a period of rapidly changing health insurance markets and health care delivery systems.

LITERATURE REVIEW

The United States has experienced unprecedented increases in health care costs in the last ten to fifteen years. Between 1987 and 1993, health insurance premiums increased by 90% even though wages and salaries increased only by 28%(Cooper, et al. 1997). Escalating health care costs coupled with increasing numbers of uninsured in the late eighties and early nineties, gave a major impetus to health care reform to contain cost, increase access, and improve quality of care. Specifically, increasing costs have resulted in pricing the small employer and low wage earners out of the health insurance market, leading to corresponding increases in the uninsured rates in the US. The 1996 Medical Expenditure Panel survey showed that 15.7% of workers in the US were uninsured compared with 12.1% in 1987 (Cooper, et al. 1997). Concern about increasing numbers of uninsured has been accentuated by the concurrent tightening of resources by safety net providers due to cost control initiatives by federal and private payers. Improving health care access for the US population remains one of the primary concerns of the federal government.

The focus of reform has been two fold, to control costs and improve access. The key strategy to control cost has been to strengthen managed care initiatives. The thrust to improve access has focused on employers and their coverage of workers, specifically on small businesses, since 51% of the uninsured worked for small businesses employing 99 or fewer workers (Morrisey et al. 1994). The increasing emphasis of health care reform on the small business sector reflects recent business trends in the United States. Between 1988 and 1995, the US economy produced 12 million new jobs, of which eight to nine million were among firms that employed 499 or fewer workers (Gable et al. 1997, www.sba.gov/advo/stats.). During this period

the overall proportion of workers in firms offering employment-based insurance coverage fell from 76.2% to 73.2% (Cooper et al. 1997). Several states undertook major policy initiatives to promote health insurance coverage by small employers, including legislation mandating specific types of benefits, facilitating purchasing alliances, and enacting small-group market reforms related to insurance rating and medical underwriting (Cooper et al. 1997; Gable et al. 1997; Helms et al. 1992).

More recently enacted federal legislation has superseded state policy initiatives to address access to health insurance for the small employer market. The effect of the proliferation of health reform legislation is mixed. Most research that has been conducted to date has examined the impact of state health insurance reform.

Nichols et al. examined the effectiveness of insurance market reforms in increasing coverage. Their study specifically focused on state-level health reforms and made inferences concerning the impact of the Health Insurance Portability and Accountability Act (HIPAA) on uninsurance, private insurance coverage, and Medicaid coverage rates. Their findings suggest that comprehensive small group insurance reform has resulted in some success but falls short of generating large changes in the numbers of uninsured (Nichols et al. 1998). McCall et al. focused on small group health insurance reform in the state of New Hampshire and concluded that establishing a community rating system, guaranteed issue, guaranteed renewal, and portability laws resulted in a decrease in the percentage of uninsured in the state and an increase in employer-based insurance (1998). Percy (1998) also found an increase in benefit offerings in the small group market in states where reform had been in place in excess of three years and for those states that had implemented all five types of reform (ratings practices, guaranteed renewal,

guaranteed issue, reinsurance, and limiting pre-existing exclusions).

Gabel et al. took a comprehensive look at rating reforms across the 50 states from 1990 to 1997 and concluded that, although states have adopted policies limiting the use of rating factors to offset possible abusive rating practices, the overall effect is questionable. Their findings were inconclusive as to the impact on administrative cost and overall cost of coverage for small employers. They argue that healthy groups may opt to drop coverage or decide to self-insure in response to increases in premiums resulting from the elimination of rating practices (1997).

Between 1996 and 1997, there was a decline of 7% in the proportion of small businesses offering health insurance, and between 1993 and 1996 small businesses experienced a decline of 31% (Morrisey et al. 1994). Morrisey reported 51% of small employers offering health insurance to their employees in 1993. The high cost of health insurance appears to be the over-riding factor inhibiting coverage. Dun and Bradstreet report, based on their annual survey of small businesses, that the average cost increase for insurance premiums was 13% in 1997 (De Mont 1998). Faced with rising costs, only 24% assumed the extra costs, while the remainder had exercised other options such as shopping for a new carrier (39%), reducing the number of providers (27%), establishing medical savings accounts (34%), or adding a co-pay plan (22%). In the Dun and Bradstreet survey, 47% of small business owners cited the high cost of health care insurance as one of their two top problems. Along similar lines, Morrisey et al. (1994), found that two thirds of small businesses that dropped health insurance coverage, blamed their action on substantially increased premiums.

Other major issues in the small business health insurance market also revolve around cost. These issues include:

1. balancing the impact on profits versus the fear of losing qualified employees due to a reduction in benefits;
2. maintaining level premiums at the expense of smaller benefit packages;
3. weighing the cost of health insurance versus eliminating coverage for employees with pre-existing medical conditions;
4. being penalized for high promotional and handling costs compared with large employers;
5. facing experience rating and medical underwriting costs as compared to larger employers;
6. balancing the different insurance needs of different employees based on wages, age, and income; and
7. having reluctance to get into administrative problems associated with managing health insurance benefits (Cooper et al. 1997; Morrisey et al. 1994; Gable et al. 1997; Cantor et al. 1995).

In-depth surveys of employers tend to confirm the primacy of the cost issue and the related issue of value for price in purchasing decisions by small employers. According to Morrisey et al., a leading reason for small firms not offering health insurance coverage, was their inability to qualify for an insurance contract at employer rates comparable to large employers (1994). Thirty-nine percent of employers who did not offer health insurance reported this as the major reason. Another 15% reported this as part of the reason for not offering health insurance coverage. Further investigation of this factor led to inconclusive findings. Only 18% of small employers said they did not qualify due to pre-existing health conditions of one or more

employees, and only 14% said it was due to being in an industry which makes them ineligible. Nine percent of employers reported being dropped by the insurer, while 66% reported dropping coverage because of cost. Morrisey also noted that small firms offered similar breadth of coverage (range of services) as the large ones, but less depth of service than the large firms (1994).

Additional research has shown that small businesses are less likely to offer health insurance, especially if they have a high proportion of low-wage earners (Gable et al. 1999). Small businesses are also less likely to pay 100% of health insurance premiums or offer coverage to dependents (Gable et al. 1999). Lastly, as premiums become a larger portion of income, eligible workers are more likely to decline coverage (Gable et al. 1999). In sum, the issue of cost appears to be the driving factor from both the employer and employee perspective in the small group market.

A frequently used solution to overcome the problem of cost has been to offer managed care plans. Notwithstanding the many issues associated with the transition from traditional indemnity insurance to managed care, it has remained the most enduring strategy to address the problem of cost escalation in health care. In the small business sector, however, managed care appears to have been less effective in achieving enough cost control to positively impact coverage. The offering of managed care plans increases with firm size, while many small employers still predominantly offer traditional health insurance plans. With increasing penetration of managed care in health care markets, the market shares of managed care plans in the small employers market has increased from 58% in 1993 to 74% in 1996 (Jensen et al. 1997). However, the proportion of small employers offering health insurance declined by 31% during

this same period. It appears that managed care plans have been attractive enough to those who offer health insurance to their employees to result in a shift from traditional insurance to managed care. But for those who have not traditionally offered health insurance coverage, managed care has not been attractive enough to entice those employers to add a health insurance benefit. Helms et al., McLaughlin et al., and Feldman et al. studied the results of demonstration projects offering subsidized HMO plans and other tailored strategies in eight states, to promote coverage in the small business sector (1992; 1992; 1993). They concluded that the practical implementation of promising strategies is ridden with operational complexities, given complex small business market scenarios.

Purchasing cooperatives were hailed as a potential solution to address insurance market failures for small groups. Morrisey reported that 59% of small employers who provided health insurance said that they had investigated the option of purchasing health insurance through a local employer coalition or trade group, but only 17% indicated that their current plan was part of such an organization (1994). Other studies have examined the lack of demand for health insurance by workers. Cooper et al. (1997) studied the take-up rate of insurance when employers offered insurance to their employees and found the many employees opt not to take the health insurance benefit. Chernew et al. (1997) studied the price elasticity of demand for health insurance using the subsidy model of inducing demand among low income workers.

An issue closely related to costs and affordability, is the health maintenance mission/vision expected of HMOs, which implies an emphasis on disease prevention and health promotion to reduce costs of health care which leads to affordability, and therefore access. Chapman et al. (1997) reported the relatively restricted range of preventive and health promotion

services provided by a sample of HMOs in the western United States. However, Schauffler et al (1998) reported considerable emphasis on a comprehensive range of preventive and health promotion services in advanced managed care markets such as those found in California.

In summary, considerable, though dated, information is available from small employers and employees of small firms. No national level data are available regarding health plans= offerings and perspectives. A study focusing on managed care insurers, particularly HMO's, and Preferred Provider Organizations (PPO), is needed in view of the continuing importance of managed care in the U.S. health care system. This study (1) addresses the impact of federal and state health insurance legislation on the use of managed care by the small business market, (2) identifies how HMO's are responding to the small businesses market. and (3) provides the small business perspective on health care insurance benefit issues.

DOCUMENTS REVIEW

A comprehensive review of Federal and State legislation as related to the small business health insurance market was conducted. The provisions of statutes and regulations are presented for 48 states and the District of Columbia. Michigan and Pennsylvania were not available. Statutes were reviewed with a major focus on ratings practices, guaranteed renewal, guaranteed issue, pre-existing conditions, reinsurance, mandated benefits, and minimum loss ratios. Appendix A provides a complete review of state regulations/legislation. A summary is included at the end of this section in Table 1.

Rating Practices. Rating practices fall into three basic categories, community rating, rating bands, and National Association of Insurance Commissioners (NAIC) rating bands. Fifteen out of 48 states and the District of Columbia have some form of community rating requiring insurers to price a given benefit plan the same for all small groups in the community, allowing differences for geography and family composition only. States more often restrict the use of health status than age for setting premium rates for small groups. Those states with the tightest rating bands were most likely to limit the use of experience rating, health status, age, gender, industry size, and type. Four of the states had regulations for tight rating bands, that are defined as setting small employer premiums in the ratio of 1.5 to 1.0, meaning that small employers could not be charged more than 150% of those premiums offered to large employers. Loose rating bands, are those that allowed premiums for small employers to be set at greater that 150% of those offered to large employers (Curtis et al. 1999). See Figure 1

RATINGS PRACTICES

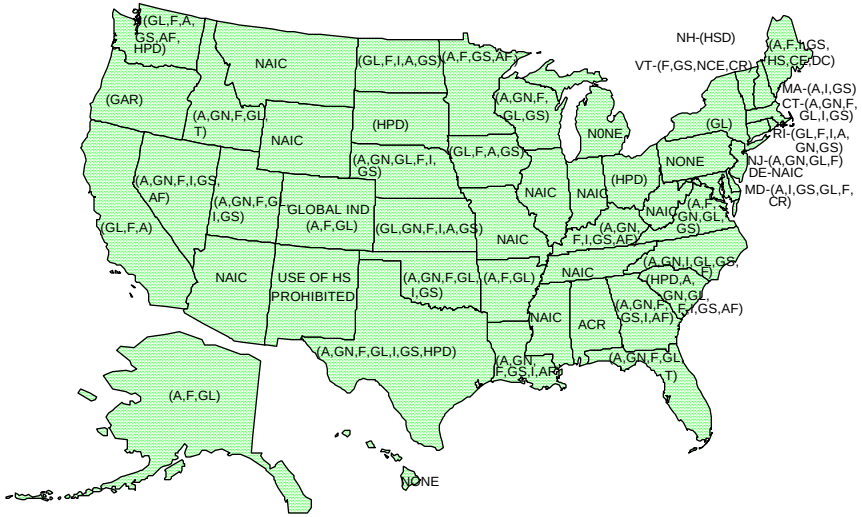


Figure 1. Ratings Practices by States

Guaranteed Renewal. Guaranteed renewal legislation, that allows businesses to renew their health insurance year-to-year regardless of the insurance company's desire to do so, was present in all states as established under the Health Insurance Portability and Accountability Act (HIPAA) and which supersedes earlier regulations in 43 states. There are only a few exceptions to guaranteed renewal that have occurred. These include: 1) health plans electing to withdraw product offerings from both the small and the large group markets; 2) groups are allowed to purchase any other insurance product; 3) health insurance plans may elect not to offer an insurance product to any small employer, effectively withdrawing from the small group market altogether; and 4) allowing an insurance company not to renew a policy to a small employer if very strict guidelines are followed, that might include documented heavy losses.

Guaranteed Issue. Guaranteed issue laws require that health insurance plans offer some insurance product to small businesses regardless of health status or claims experience. Only two states (IL, IN) have no guaranteed issue laws. Guaranteed issue regulations vary tremendously from state to state. Some states have specific basic plans that must be offered, while other states have no provisions for a standard or basic plan. As result, insurance plans in states without a stipulated basic plan, will offer plans with substantially reduced benefits to offset the guaranteed issue regulations. The effect of guaranteed issue has been shown to significantly increase coverage in the small business group market, but without regard to types and numbers of insurance benefits (Nichols et al. 1998). See Figure 2

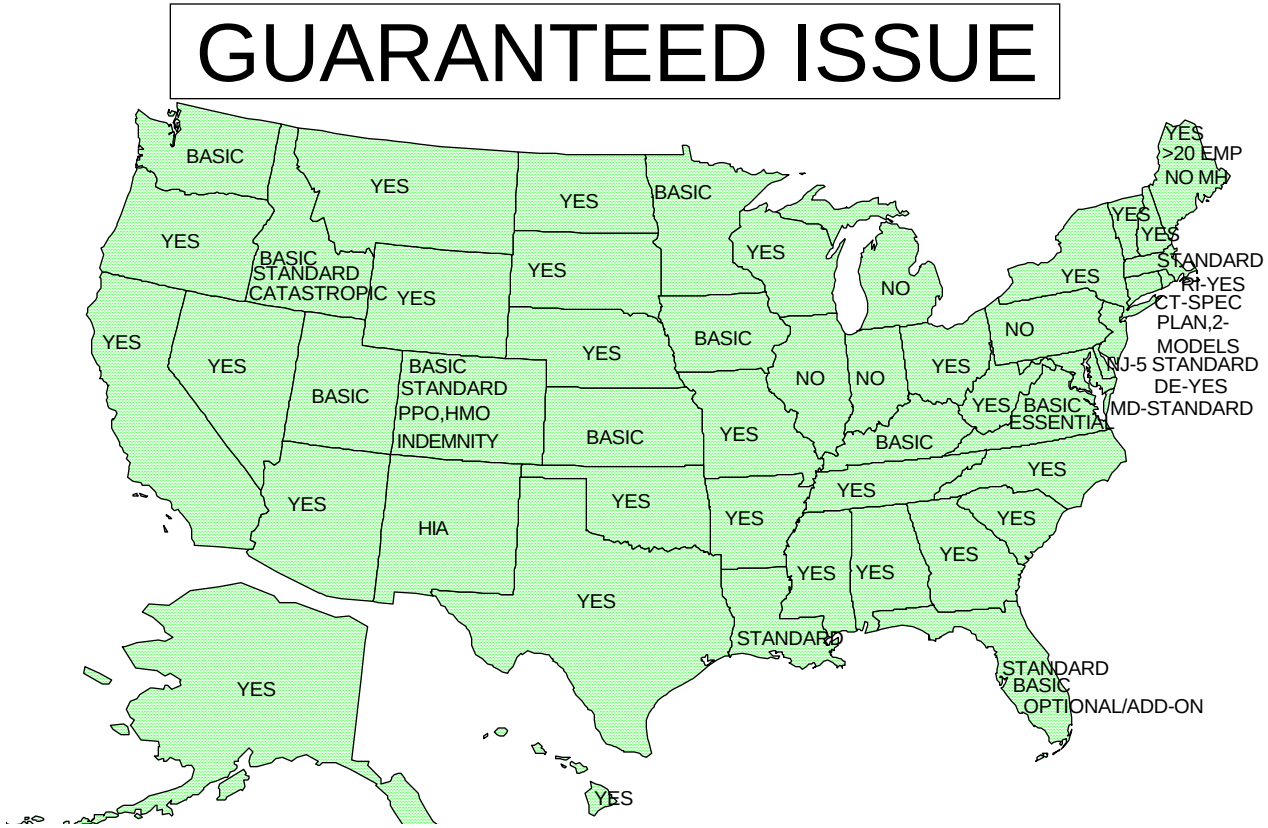


Figure 2. Guaranteed Issue Regulations by States

Pre-existing Conditions. Pre-existing conditions legislation limits pre-existing exclusions in policies. All states having small business health insurance regulations have some form of limitation on exclusions of pre-existing conditions. The effect of limiting pre-existing condition exclusions has not been demonstrated to be effective in the literature (Nichols et al. 1998; McCall et al. 1998). This study did not find an association between pre-existing condition legislation and the trend in the number of uninsured. See Figure 3

Reinsurance Laws. Reinsurance laws refer to regulations that allow health plans to insure themselves against extensive loss. In some states there exists a statutory, non-profit entity that is established under the auspices of the State Insurance Commission to reinsure small employee groups or health plans offering insurance to small employers. In some states, reinsurance laws allow some insurers to perform this function (for-profit), but if they do so, they cannot offer primary insurance to the small businesses themselves. The effect of reinsurance laws is to spread risk over a number of health insurance plans and companies, and by doing so, enables insurers to take greater risks in their offerings to small businesses, resulting in lower premiums. This study indicates, for each state, whether the state required (mandatory) reinsurance, or whether it is voluntary. See Figure 4. There are no Federal regulations on reinsurance.

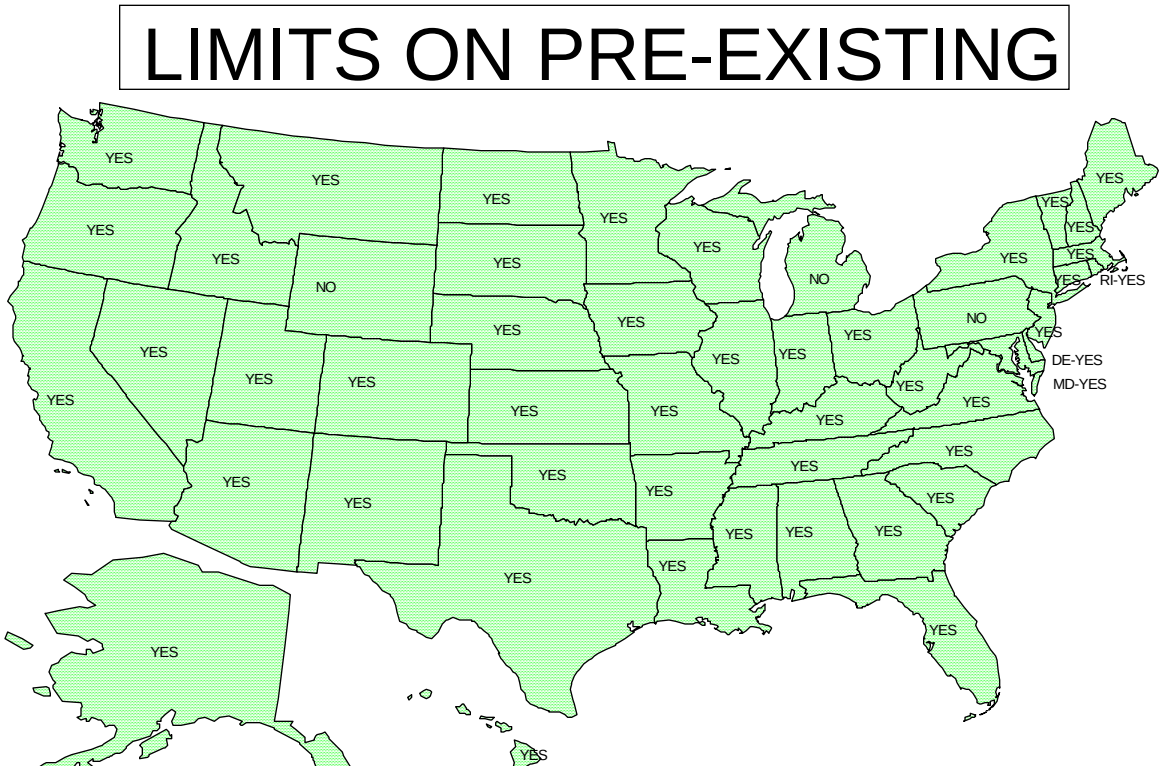


Figure 3. Limits on Pre-Existing Conditions

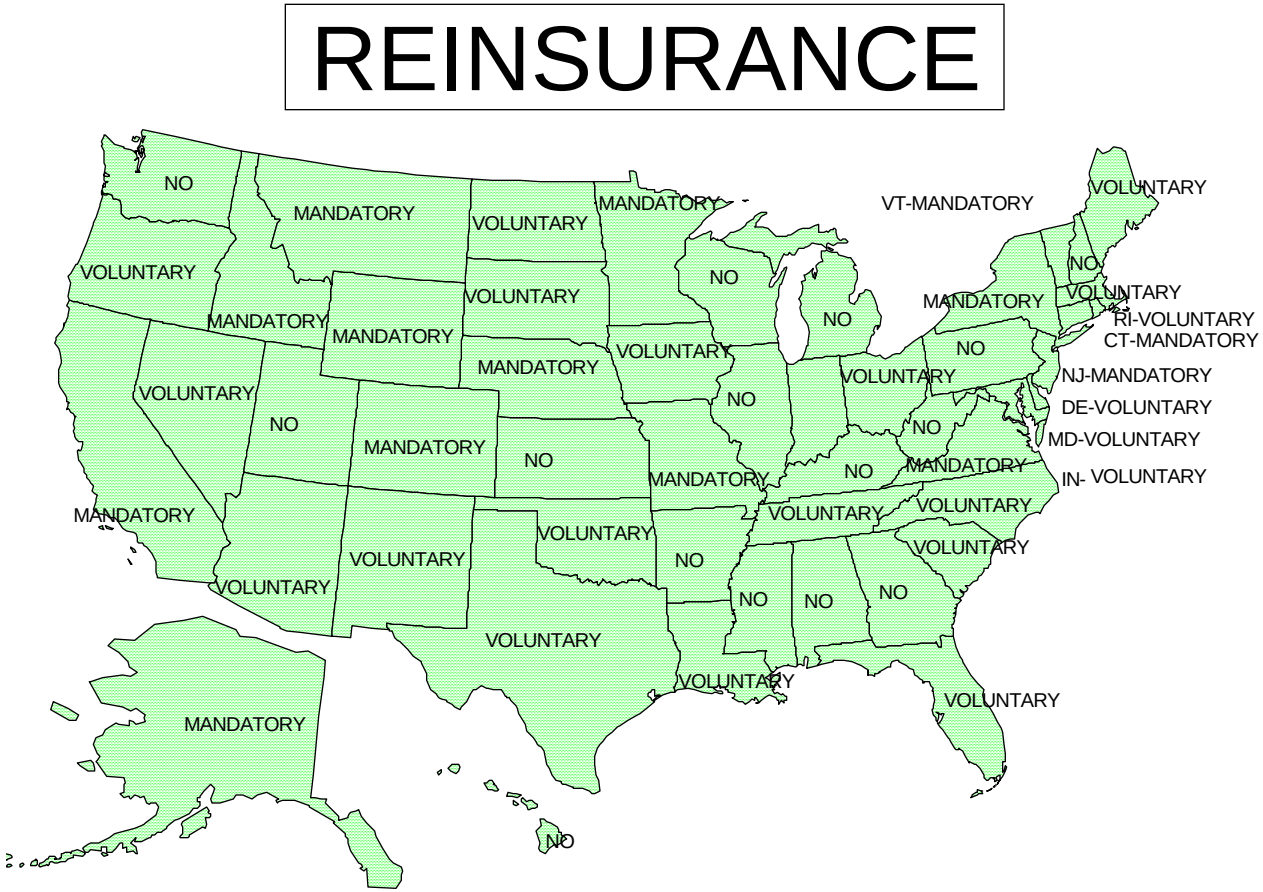


Figure 4. Reinsurance Laws by States

Mandated Benefits. Mandated benefits are those benefits that are required to be offered in each health plan written for small businesses. States vary widely on mandated benefits. See Figure 5. Jensen and Morrisey (1999) estimate that 20 to 25% of the uninsured lack coverage because of mandated benefits. Jensen and Morrisey (1998) found that workers report that mandated benefits impact their paychecks through decreased wages, fewer benefits, and higher premiums. Dental services have been shown to result in the highest percentage increase in premiums (15%), followed by visits to psychologists (12%), psychiatric hospital stays (13%), and chemical dependency (9%) (Jensen and Morrisey, 1998).

The most common mandates observed across the states in this study were mammography screening, chemical dependency/alcohol treatment, maternity benefits, immunizations, and mental health. Among mental health mandates, states have tremendous latitude in what services and how often they cover certain services, such as numbers of visits (generally a minimum of ten per year) to a psychologist or psychiatrist, numbers of inpatient treatment days (generally a minimum of 30 days), and caps on total expenditures per year. South Dakota provides for biologically-based mental illnesses, such as schizophrenia, bipolar disorder, and any other diagnosis that causes serious impairment to functioning, to be paid as other physical illnesses. Texas, on the other hand, does not require reimbursement of substance abuse treatment when the substance was obtained and consumed in violation of the law.

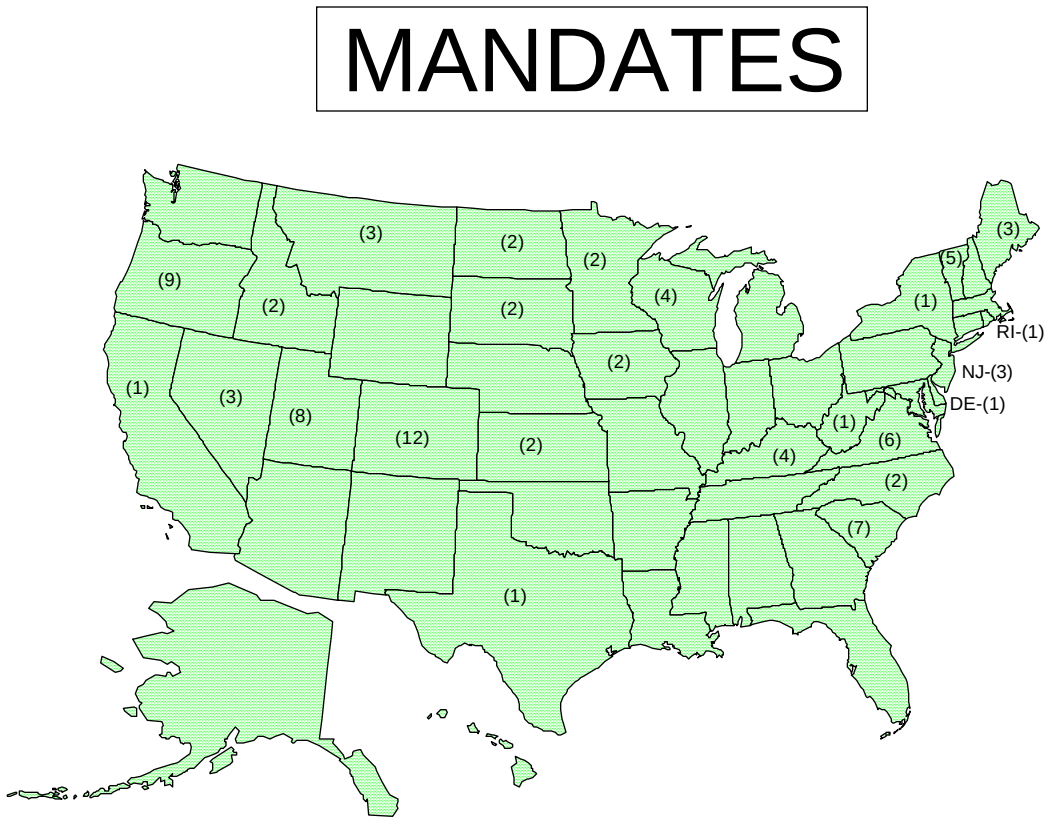


Figure 5. Number of Mandated Benefits by State

Minimum Loss Ratio. Minimum loss ratio refers to the proportion of premiums collected that should be paid out in claims. Eight out of the 48 states and the District of Columbia had either prescribed minimum loss ratios or prescribed guidelines for arriving at minimum loss ratios. These ratios ranged from 50% in Minnesota to 80% in Washington. There are two states (NY, NJ) that stipulate that if a carrier paid out less than 75% in the prior year, they must pay out the balance as dividends or credits against subsequent premiums to employers. There is no Federal legislation directed toward minimum loss ratios. See Figure 6. for a sample of states which stipulate minimum loss ratios.

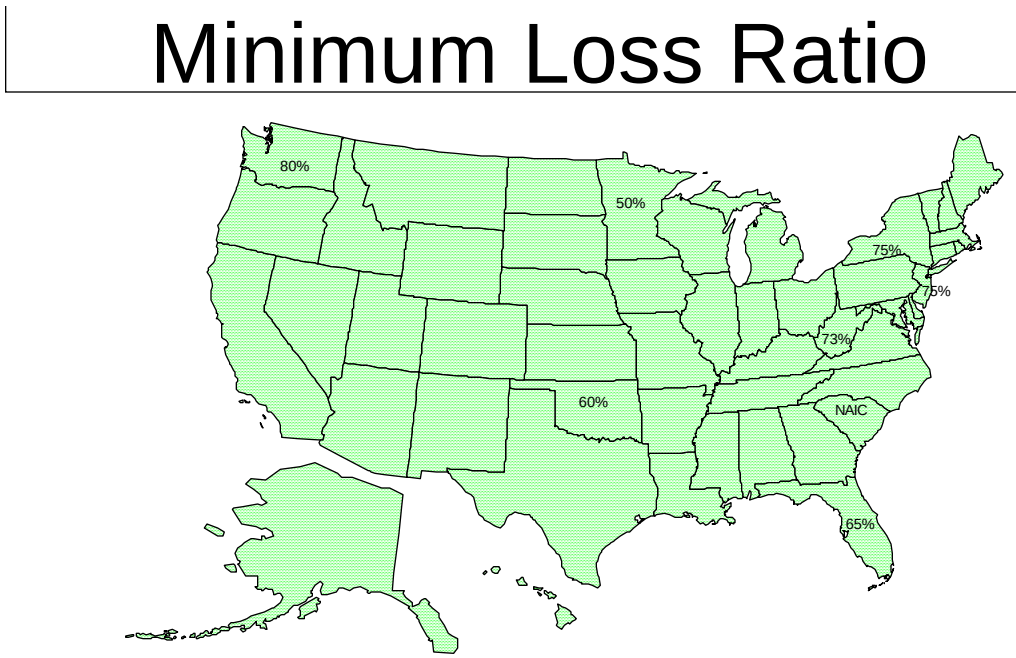


Figure 6. Minimum Loss Ratio by States

In the course of reviewing these dimensions of state regulations/legislation, it was found that although Federal regulation is silent on continuation of coverage of employees after termination of employment or loss of eligibility, some states have made provision for continued coverage through such mechanisms as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), maintenance of coverage at the same premium level, or a premium that cannot exceed some percentage of the group rate. The Health Insurance Portability and Accountability Act (HIPAA) provided for portability, which is defined as the ability to go from one insurance plan to another without having to go through medical examinations or having to meet new waiting periods for existing conditions. To date, only 35 states have specifically adopted the HIPAA regulation as a state law.

Summary. The comprehensive review of health insurance regulations across the states did not uncover any significant patterns that could be associated with the number of uninsured in each state. The mixed results suggest a different approach to determine the impact of legislation on access to health insurance for small employers. There are a number of major factors that confound the findings in this state document review, such as individual state policies and laws concerning Medicaid coverage and eligibility, Children's Health Insurance Plan (CHIP) regulations, and welfare to work programs. In addition, each state has a unique economy, many of which are booming at this time (low unemployment, lack of qualified employees in many sectors, stable tax base), resulting in employers= willingness to provide more extensive employee benefits. As seen in the Robert Wood Johnson Foundation's, Community Snapshots Project through the Center for Studying Health System Change, communities vary tremendously in their health care markets. And the health care markets have a complex and intertwining relationship with both the small and large members

of the business community. Each community, or state, has unique catalysts that impact the dynamics of the health insurance industry and other industries. These markets also operate in the context of widely varying social and political environments. These complexities mask any discernable relationships between the numbers of uninsured and state regulations.

One approach to standardizing the various health insurance markets across states, is to have more and stronger Federal legislation as related to the small business insurance market. Of particular interest are those areas where states have tremendous latitude in setting their own regulations, such as establishing a national reinsurance guidelines for small groups, and establishing purchasing pools at a state level and providing support of the administration of those pools.

Table 1. Summary of Regulations/Legislation By State

State	Trend Uninsured 97/96/95(a)	Ratings Practices	Guaranteed Renewal	Guaranteed Issue	Reinsurance Vol(b)	Reinsurance Man(c)	Limit Pre-existing Exclusions	Minimum Loss Ratio	Mandates
AL	Inc/dcr/inc	Adjusted Community Rating	Yes	Yes			Yes		
AK	Inc	Age, Family, Geographical Location	Yes	Yes		Yes	Yes		
AZ	Inc	NAIC(d)	Yes	Yes	Yes		Yes		
AR	Inc	Geographical Location, Age, Family	Yes	Yes					
CA	Inc/dcr/inc	Geographical Location, Family, Age	Yes	Yes		Yes	Yes		Basic Health Care
CO	Dcr	Global Index, Age, Geographical Location, Family	Yes	Basic Standard PPO Indemnity HMO		Yes	Yes		Inpatient, Mammogram, Maternity Immunizations, Family Planning, Smoking Cessation, Child Care, Adopted Children, Outpatient, Emergency out of area, Handicapped, Prostate Screening
CT	Inc	Age, Gender, Family Geographical Location, Industry, Group Size	Yes	Special Plan 2-Models		Yes	Yes		
DE	Dcr	NAIC	Yes	Yes	Yes		Yes		Mental Health
FL	Inc	Age, Gender, Family, Geographical Location, Tobacco		Standard, Basic, Optional, Add-on	Yes		Yes	65%	
GA	Dcr	Age, Gender, Family, Group Size, Industry, Avocational Factors	Yes	No mention of Basic, Standard, or Special Plans			Yes		
HI	Dcr		Yes	Yes			Yes		
ID	Inc	Age, Gender, Family, Geographical Location, Tobacco	Yes	Basic, Standard, Catastrophic		Yes	Yes		Maternity, Immunization
IL	Inc	NAIC	Yes	No			Yes		
IN	Inc/dcr/inc	NAIC	Yes	No	Yes		Yes		
IA	Inc	Geographical Location, Family, Age, Group Size	Yes	Basic	Yes		Yes		Maternity, Immunization
KS	Inc/dcr/inc	Geographical Location,	Yes	Basic	Yes		Yes		Medically Uninsurable,

		Gender, Family, Industry, Age, Group Size							Mental Health

Table 1. Summary of Regulations/Legislation By State - Continued

State	Trend Uninsured 97/96/95(a)	Ratings Practices	Guaranteed Renewal	Guaranteed Issue	Reinsurance Vol(b)	Reinsurance Man(c)	Limit Pre-existing Exclusions	Minimum Loss Ratio	Mandates
KY	Dcr/inc/dcr	Age, Gender, Family, Industry, Group Size, Avocational Factors	Yes	Basic		Yes	Yes		Medically Uninsurable, Maternity, Immunizations, Alcohol
LA	Dcr	Age, Gender, Family, Group Size, Industry, Avocational Factors	Yes	Standard Plan	Yes		Yes		
ME	Inc/dcr/inc	Age, Family, Industry, Group Size, Health Status, Claims Experience, Duration of Coverage		Yes; >20 Employees-No Mental Health	Yes		Yes		Maternity, Immunizations, Mental health
MD	Inc/dcr/inc	Age, Industry, Group Size, Geographical Location, Family, Community Rating	Yes	Standard Plan	Yes		Yes		Maternity, Immunizations, Mental health
MA	Inc	Age, Industry, Group Size	Yes	Standard Plan	Yes		Yes		
MI(e)	Inc/dcr/inc		Yes						
MN	Dcr	Age, Family, Group Size, Avocational Factors, Use of Gender Prohibited	Yes	Basic Plan Only		Yes	Yes	50%	Maternity, Immunizations
MS	Inc/dcr/inc	NAIC	Yes	Basic Plan Only			Yes		
MO	Dcr	NAIC	Yes	Yes		Yes	Yes		
MT	Inc	NAIC	Yes	Yes		Yes	Yes		Maternity, Immunizations, Mental Health
NE	Dcr/inc/dcr	Age, Gender, Geographical Location, Family, Industry, Group Size	Yes	Yes		Yes	Yes		
NV	Inc/dcr/inc	Age, Gender, Family Industry, Group Size, Avocational Factors	Yes	Yes	Yes		Yes		Basic Health Care, Maternity, Immunizations
NH	Inc/dcr/inc	Health Status Discount	Yes	Yes			Yes		
NJ	Inc/dcr/inc	Age, Gender, Geo, Family	Yes	5 Standard Plans	Yes	Yes	Yes	75%	Maternity, Immunizations, Alcohol
NM	Dcr	Use of Health Status Prohibited	Yes	HIA Plan (f)	Yes		Yes		

NY	Inc	Geographical Location	Yes	Yes		Yes	Yes	75%	Risk Pool
NC	Dcr/inc/dcr	Age, Gender, Industry, Geographical Location, Group Size, Family	Yes	Yes	Yes		Yes		Maternity, Immunizations

Table 1. Summary of Regulations/Legislation By State B Continued

State	Trend Uninsured 97/96/95(a)	Ratings Practices	Guaranteed Renewal	Guaranteed Issue	Reinsurance Vol(b)	Reinsurance Man(c)	Limit Pre-existing Exclusions	Minimum Loss Ratio	Mandates
ND	Inc	Geographical Location, Family, Industry, Age, Group Size (With Prior Approval)	Yes	Yes	Yes		Yes		Pre-natal Care, Immunizations
OH	Dcr	Health Promotion Discount	Yes	Yes	Yes		Yes		
OK	Inc/dcr/inc	Age, Gender, Family, Geographical Location, Industry, Group Size	Yes	Yes	Yes		Yes	60%	
OR	Dcr/inc/dcr	Geographic Average Rate	Yes	Indemnity HMO Basic Plan	Yes		Yes		Medically Uninsurable, Family Planning, Women & Children, Maternity, Immunizations, Alcohol, Prevention, Chemical Dependency
PA(g)	Inc/dcr/inc		Yes						
RI	Inc/dcr/inc	Geographical Location, Family, Industry, Age, Gender, Group Size	Yes	Yes	Yes		Yes		Mental Health
SC	Dcr/inc/dcr	Health Promotion Discount, Age, Gender, Geographical Location, Family, Industry, Group Size, Avocational Factors	Yes	Yes	Yes		Yes	NAIC	Prevention, Women and Children, Prostate Screening, Maternity, Immunizations, Mental Health
SD	Inc	Health Promotion Discount	Yes	Yes	Yes		Yes		Maternity > 15 Employees, Mental Health
TN	Dcr/inc,dcr	NAIC	Yes	Indemnity, HMO, Basic Plan, Standard Plan	Yes		Yes		
TX	Inc/dcr/inc	Age, Gender, Family, Geographical Location, Industry, Group Size, Health Promotion Discount	Yes	Basic Plan Catastrophic	Yes		Yes		Mental Health
UT	Inc	Age, Gender, Family, Geographical Location, Industry, Group Size	Yes	Basic Plan			Yes		Family Planning, Alcohol, Chemical Dependency, Prevention, Women and Children, Maternity > 15 Employees, Mental Health
VT	Dcr	Family, Group Size, No Claims Experience Community Rating	Yes	Yes		Yes	Yes		Family Planning, Prevention, Women and Children, Mental Health

Table 1. Summary of Regulations/Legislation By State - Continued

State	Trend Uninsured 97/96/95(a)	Ratings Practices	Guaranteed Renewal	Guaranteed Issue	Reinsurance Vol(b)	Reinsurance Man(c)	Limit Pre-existing Exclusions	Minimum Loss Ratio
VA	Inc/dcr/inc	Age, Gender, Family, Geographical Location, Group Size	Yes	Essential Plan, Standard Plan		Yes	Yes	
WA	Dcr/inc/dcr	Geographical Location, Family, Age, Group Size, Avocational Factors, Health Promotion discount, Use of Gender Prohibited	Yes	Basic Plan			Yes	Yes
WV	Inc/dcr/inc	NAIC	Yes	Yes			Yes	73%
WI	Dcr/inc/dcr	NAIC	Yes	Yes			Yes	
WY	Inc/dcr/inc	Age, Gender, Family, Geographical Location, Group Size	Yes	Yes		Yes		

Notes:

(a) Trends in Uninsured Rates for 1995, 1996, 1997 From Census Data

(b) Voluntary Reinsurance Regulations

(c) Mandatory Reinsurance Regulations

(d) National Association of Insurance Commissioners

(e) Michigan's Statutes Did Not Specifically Address the Small Employer Market

(f) Health Insurance Alliance

(g) Pennsylvania Statutes Did Not Specifically Address the Small Employer Market

(h) Inc : Increasing, Dcr : Decreasing

employer market across six dimensions (ratings practices, guaranteed issue, reinsurance, limits on pre-existing exclusions, minimum loss ratios, and benefit mandates). Some states have not adopted any small business health insurance regulations (MI and PA), while others have adopted all six types of legislation, such as New Jersey and South Carolina. The other states include GA and IL (3 of 6), MO and TN (4 of 6), and CA and TX (5of 6). These states are also geographically distributed and represent states with different economic bases.

Source of HMO Listing:

The Executive Managed Care Directory B 1999, A Comprehensive Reference to Managed Care Suppliers and Plans, served as the source of information on HMOs to be contacted. All 439 HMOs listed were contacted to complete the survey. The list of HMOs along with the names of the respective contact persons to whom the survey was faxed/from whom information was received is included in Appendix B.

Survey Methodology:

Marketing vice-presidents or directors of three HMOs in Columbia, South Carolina, were personally interviewed to pilot test and refine the draft survey instrument. The final format of the survey used is included in Appendix C.

Three interviewers were trained to administer the survey. Marketing representatives from the respective organizations were identified as the appropriate contact person to provide the requested data. In most organizations, the Vice President of Marketing or the Director of Marketing received the survey. Following an introductory call, the survey was faxed to the

completed for a completion rate of thirty-two percent (32%). Three surveys were completed over the telephone, one was received by email, and the remaining 15 were received by fax.

Distribution of HMOs

The distribution of HMO plans by state is presented in Table 2. Of the total 439 organizations contacted, the number of organizations from which a completed survey could potentially be expected was 158 as reflected in the table. Sixty-nine HMOs responded to the initial contact, but only 22 HMOs were operational in the small employer market and completed and returned the survey in its entirety.

TABLE 2
Distribution of HMOs listed in the Directory by State

Status on contacting the organization	CA	GA	IL	MI	MO	NJ	PA
Total HMOs listed in the directory	130	22	40	41	30	24	39
Corporate office at another location in the state (multiple regional office listings in other cities of the same state)	21	0	7	16	4	5	7
Phone disconnected. Unable to trace organization through telephone directories and assistance.	8	2	2	2	1	2	1
No response/automated voice mail with no option for reaching operator/message left	16	3	1	1	0	0	1
Operator declined to provide fax numbers, and no response to repeated messages on voice mail	0	0	0	1	0	0	0
Declined to participate	7	1	2	2	3	1	8
Merged/acquired by another HMO/insurance company	7	2	4	2	4	2	3
Out of business	2	0	0	0	0	3	1
HMO business in the small business sector being phased out	0	0	0	0	1	0	0
Phasing out managed care business	0	0	1	0	0	0	0
Not an HMO, only indemnity insurance/PPO/POS/IPA	18	0	2	2	1	1	0
Not an HMO, only third party administrator/marketing agent	1	0	1	0	1	0	0
Not an HMO, a behavioral care/mental health managed care organization	0	0	0	1	0	0	1
Not an HMO, only life insurance/dental insurance/supplemental health insurance	1	2	0	0	0	0	0
Not an HMO, offers insurance to HMOs (reinsurance)	1	0	0	0	0	0	0
No commercial HMO plans, only self-insured plans	1	0	0	0	0	2	0
No commercial HMO, Medicaid/Medicare HMO only	1	0	0	1	0	1	1
Not an HMO, a hospital system	0	0	0	1	0	0	0
No small business plans, only for large businesses	2	0	1	0	1	0	0
No HMO plan in this state	0	0	1	0	0	0	0
Survey faxed/emailed, response awaited	38	11	17	10	10	7	13
Completed survey	6	1	1	2	4	0	3

for-profit and 50% were private not-for-profit. Of the18 HMOs that answered the question pertaining to the types of managed care products offered, 16 offered a HMO product, 14 offered a Point-of-service (POS) product, and 10 offered a Preferred Provider Organization (PPO). Sixteen offered at least two products.

The mean number of base plans offered by HMOs to all sizes of businesses is 9.73. The mean number of base plans offered to the small business sector is only 3.52. (See Figure 7) Thirteen (13) out of 20 HMOs required at least 75% employee participation to enroll a small business in a health plan, and 13 out of 20 required a minimum employer contribution of 50% to the employee premium. Most did not mandate minimum employer contribution for dependent premiums.

Of the 21 respondents to this questions, 15 had plans specially designed for small businesses. To encourage small businesses to enroll in their health plans, a majority (13 out of 20) offered a low cost(basic)plan, 11 out of 20 provided administrative support for claims administration and clarifications, 13 provided drug formularies, and 19 provided maternity benefits.

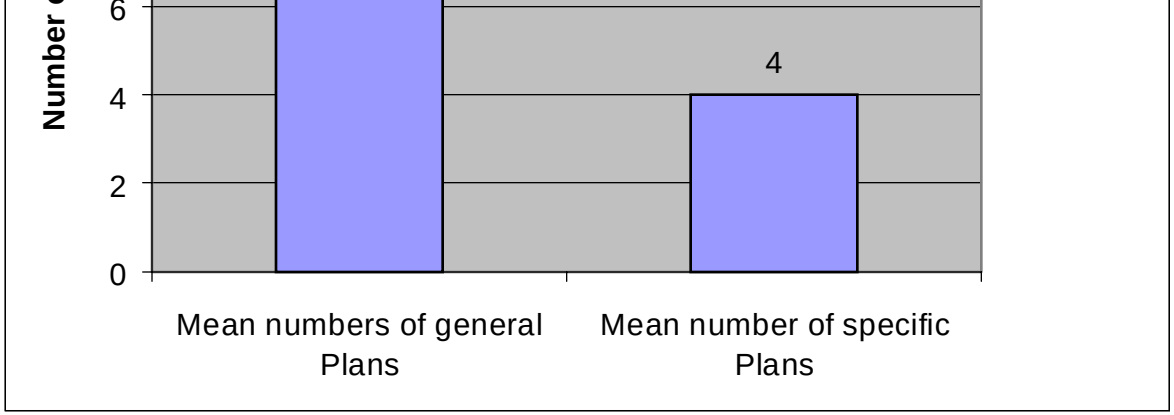


Figure 7. Mean Difference by Type of Plan

Plan Features and Benefits

HMOs were asked about specific features and options of their three most popular plans in the small business sector. Of the 22 companies responding, one had moved out of the small business sector, two had only one managed care plan for small businesses, and 18 reported two plans were offered to small businesses.

Of the most popular HMO plans in the small business sector, 68% (34 out of 50 plans) had specifically assigned primary care physicians for members, 78% (39) had their primary care physicians function as gatekeepers to control service utilization, 44% (22) paid their physicians/practices on a capitated basis, and 72% of the plans (36) paid

	Yes (%)	No (%)	Total plans(%)
Primary Care Physician or Practice	34 (68.0)	16 (32.0)	50 (100.0)
Primary Physician As Gatekeeper	39 (78.0)	11 (22.0)	50 (100.0)
Capitation Payment for Physician/Practice	22 (46.8)	25 (53.2)	47 (100.0)
Contact Based Payment for Physician/Practice	36 (73.5)	13 (26.5)	49 (100.0)

Ninety four percent (47) of the plans required a co-pay for office visits, 66% (33 plans) imposed a penalty on the patient for using an emergency room for primary care, 90% (45 of 50 plans) had a drug benefit, and almost all (49 of 50) required patients to use specific pharmacies. Most of the plans had drug formularies (44 out of 50), required a co-pay per prescription (48 out of 50), and had a provision for generic prescriptions (46 out of 49 responses). See Table 4. and Figure 9.

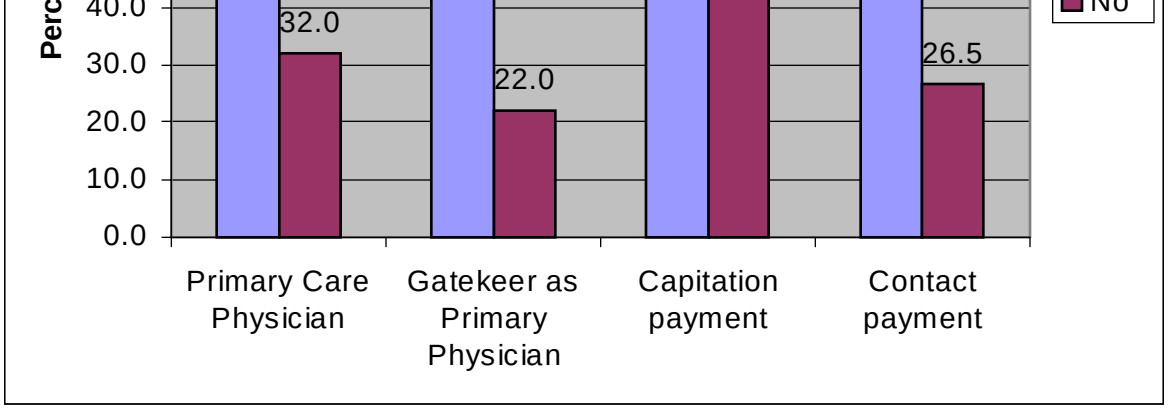


Figure 8. HMO Payment Mechanisms for Physicians

Table 4. HMO Cost Control Features

	Yes (%)	No (%)	Total plans (%)
Co-payment for a Office Visit	47 (95.9)	2 (4.1)	49 (100.0)
Penalty for Using an ER for Primary Care	36 (80.0)	9 (20.0)	45 (100.0)
Have a Drug Benefit	45 (95.7)	2 (4.3)	47 (100.0)
Patient Required to Use a Specific Pharmacy	49 (100.0)	0 (0.0)	49 (100.0)
Drug Formulary	44 (89.8)	5 (10.2)	49 (100.0)
Co-Payment per Prescription	48 (98.0)	1 (2.0)	49 (100.0)
Generic Prescription	46 (93.9)	3 (6.1)	49 (100.0)

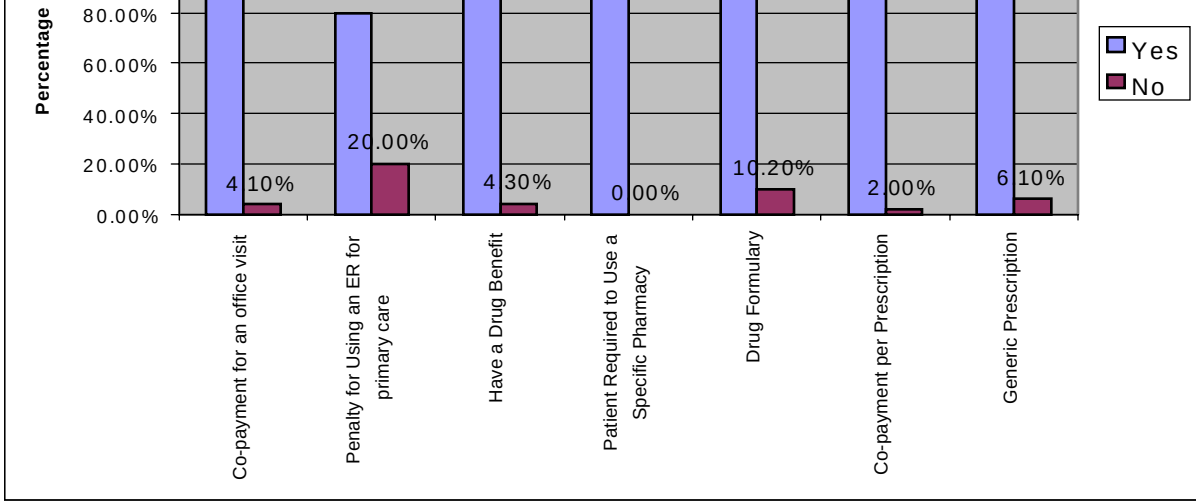


Figure 9. Cost Sharing by Enrollees and Cost Control Features

offered free or nominal co-pay childhood immunizations. Ninety-four percent of the plans (47 out of 50) offered disease prevention or health promotion activities to enrollees, and an equal percentage actively attempted to educate enrollees on how best to use the plan benefits. See Table 5 and Figure 10.

Table 5. Preventive Services Offered in the Plans

	Yes (%)	No (%)	Total (%)
Immunizations free/nominal co-payment	46 (92.0)	4 (8.0)	50 (100.0)
Mammography free/nominal co-payment	43 (86.0)	7 (14.0)	50 (100.0)
Prenatal Care	31 (69.0)	14 (31.0)	45 (100.0)
Childhood Immunization	30 (60.0)	15 (40.0)	45 (100.0)
Disease prevention or Health promotion activity	47 (94.0)	3 (6.0)	50 (100.0)

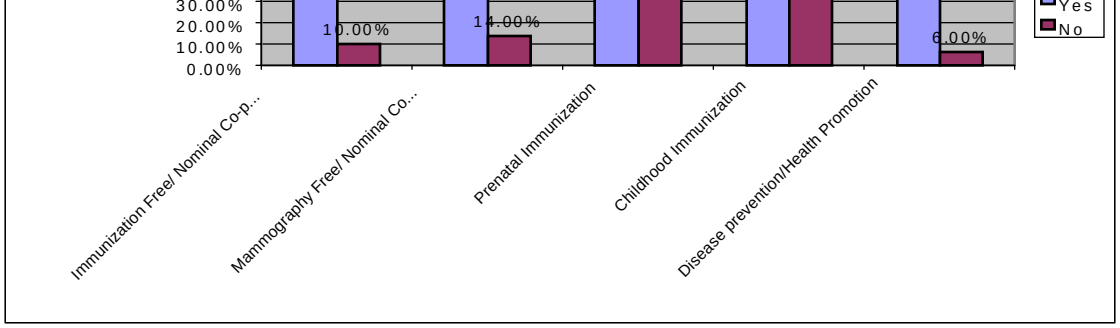


Figure 10. Preventive Services Offered in the Plans

In responding to the question on other services, ninety-four percent (47 out of 50) offered maternity benefits. Only 48% (24 out of 50) of the plans offered dental benefits. All plans reported offering mental health benefits, with 24% (12) treating it as a carve-out, 78% (39) limited the number of visits per year, and 34% (17) imposed a dollar limit per year. All plans offered physical therapy benefits, mostly limited in number and scope, and 96% offered speech therapy. See Table 6 and Figure 11.

Mental Health Benefit	50 (100.0)	0 (0.0)	50 (100.0)
- Treated as a carve-out	12 (24.5)	37 (75.5)	49 (100.0)
- Limited number of visits per year	39 (79.6)	10 (20.4)	49 (100.0)
Physical Therapy	50 (100.0)	0 (0.0)	50 (100.0)
- Limited number and scope	45 (90.0)	5 (10.0)	50 (100.0)
Speech Therapy	49 (98.0)	1 (2.0)	50 (100.0)

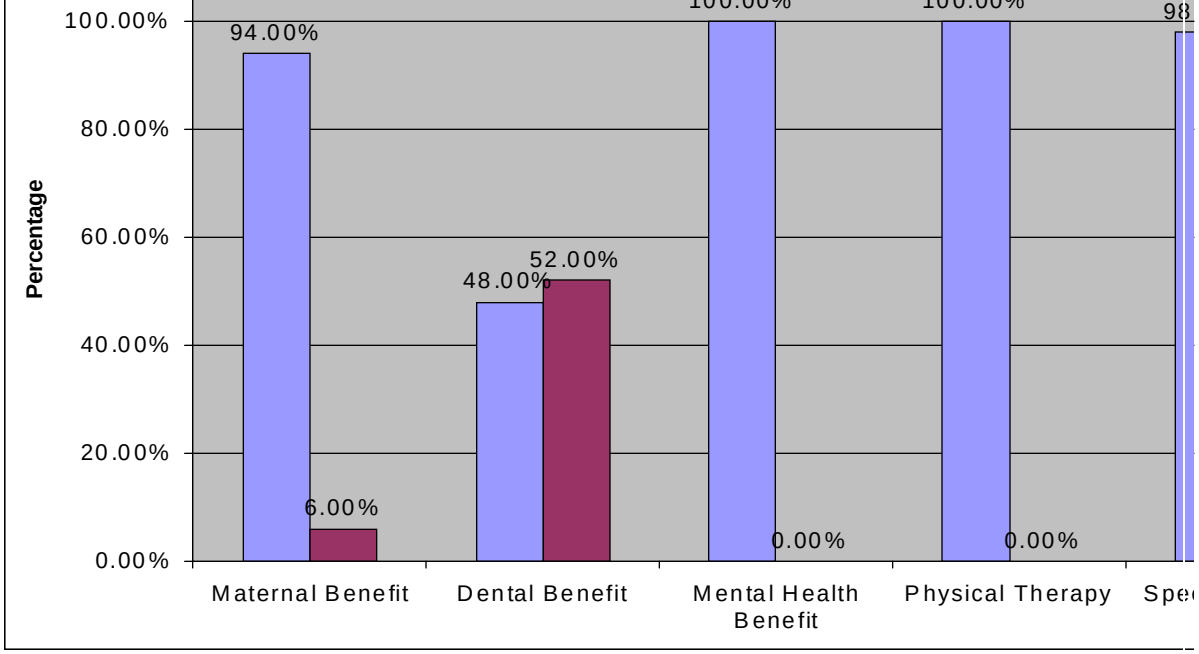


Figure 11. Other Benefits

Although 22 plans reported having capitated payment arrangements, only 4 plans provided information regarding capitation payments from physicians. These four did not withhold capitation payments based on physician performance. Only 48% (24) of the plans required pre-certification for outpatient procedures, compared to 78% (39) requiring pre-certification for hospitalization. Eighty eight percent (44 of the 50 plans) of the plans had provisions for concurrent management of hospitalization. See Table 7.

Hospitalization Managed by the HMO	44 (88.0)	6 (12.0)	50 (100.0)
Educate enrollees on use of benefits	45 (93.8)	3 (6.2)	48 (100.0)

The respondents were also asked a series of questions on their perspective of the issues concerning small employers and the small employer insurance market.

The 22 respondents offered the following reasons why they believed small employers provide health insurance benefits to their employees: 1) need to attract and retain employees (21); 2) respond to employee demands for coverage (17); 3) the tight labor market (10); and 4) to get coverage for only the owner and family(14). Of these reasons, attracting and retaining employees was indicated as the single most important reason. See Tables 8 and 9.

Table 8. Reasons Small Businesses Provide Health Insurance

	Yes (%)	No (%)	Total Plans (%)
Attract & Retain current employees	21 (95.5)	1 (4.5)	22 (100)
Tight labor market	10 (45.5)	12 (54.5)	22 (100)
Respond to employee demands for coverage	17 (77.3)	5 (22.7)	22 (100)
Coverage for owner & family	14 (63.6)	8 (36.4)	22 (100)

Table 9. Priority of Reasons Small Employers Provide Health Insurance

Reasons	Number of companies	Percentage
Attract & Retain current employees	9	45%
Respond to employee demands for coverage	3	15%

Total	20	100%

Of the 22 respondents, almost all (20) indicated that cost was the major reason for employers not offering health insurance coverage. Most felt there are adequate choices for plans in the market, and also believe small employers are being provided adequate information about plans and options. See Tables 10 and 11.

Table 10. Reasons Small Business Don=t Provide Health Insurance

Reasons	Yes (%)	No (%)	Total plans (%)
Not affordable	20 (90.5)	2 (9.5)	22 (100)
High employee turnover	12 (57.1)	9 (40.9)	21 (100)

Table 11. Priority of Reasons Small Employers Do Not Provide Health Insurance

Reasons	Number of Companies	Percentage
Not Affordable	14	87.5%
Lack of information about options	1	6.25%
Any others	1	6.25%
Total	16	100%

Respondents were asked to provide what percent of their small business voluntarily elected not to renew. Of the total 12 respondents that answered this question, 9 reported that 10% or more of small employers voluntarily terminated their health insurance coverage with their plan and six reported 20% or more voluntary terminations in the previous year. See

Table 12. HMO ' s Non-renewal Rate of Small Businesses

Non-renewal Rate	Number of Companies	Percentage
less than 9 %	3	25%
10% or higher	9	75%
Total	12	100%

Ten of 18 respondents reported that their state had expanded Medicaid coverage to include the working poor. In response to the perceived effect of such state legislation on the small employer market, eight out of 16 believed that flexibility had decreased and adversely impacted their market share. All respondents indicated increased costs, decreased affordability, and decreased real access associated with recent state and federal legislation. See Table 13.

Table 13. Perceived Impact of State and Federal Legislation on Small Business Insurance

Reasons	Number of Companies	Percentage
Decreased	2	18.2%
Increased	1	9.1%
Stayed	8	72.7%
Total	11	100%

Survey respondents were asked about pooled purchasing in their respective state and the degree to which they felt it was an effective mechanism for improving access to health insurance for the small employer. Nine respondents indicated the presence of pooled

respondents, 13 had a smoking cessation program, seven had a physical activity promotion program, nine had a stress management program, eight had both a healthy nutrition promotion program and a weight reduction program, three had an asthma management program, and only one had an alcohol abuse program. A variety of program strategies were reported for the health promotion services provided by the plans to include, individual personal counseling for smoking cessation and stress management (2), phone counseling for physical activity (1), smoking cessation, nutrition, weight management, and stress management (1); educational videotapes for smoking cessation (2), and referrals to community services for all five programs listed above (2). The only major physical activity promotion program consisted of a fitness facility membership discount that was offered by seven HMOs. Thirteen out of 22 respondents offered incentives to members to participate in health promotion programs: free gifts (3), free educational materials (3), gift certificates (1), reduced premiums (1), and a one time cash gift (1). Twelve of the 17 plans with a health promotion program evaluated the program through participation rates (9), cost effectiveness (6), member satisfaction (11), change in health care costs (4), and change in health behaviors (7). When asked whether their HMO informed primary care providers about members= participation in health promotion activities, seven of the 16 plans responding to the question reported in the affirmative. Of the 17 respondents, five subsidized work site health promotion programs, mostly a fully subsidized educational program. Nine of the 16 who answered this question,

Physical activity	7 (38.9)	11 (61.1)	18 (100)
Proper nutrition	8 (44.4)	10 (55.6)	18 (100)
Weight Mgt	8 (44.4)	10 (55.6)	18 (100)
Smoking cessation	13 (72.2)	5 (27.8)	18 (100)
Stress Mgt	9 (50.0)	9 (50.0)	18 (100)

Table 15. Health Promotion Program Strategies

	Health Behavior				
Programs	**Physical activity**	**Proper nutrition**	**Weight Mgt**	**Smoking cessation**	**Stress Mgt**
Individual counseling in person				2	2
Individual counseling via phone	1	2	2	2	1
Health advice line	6	8	7	8	8
Free Classes	1			1	
Subsidized classes	4	4	5	3	3
Member newsletter	9	10	9	12	11
Printed self-help matericals	3	5	3	5	5
Educational videotapes				2	
Referral to Community Services	2	3	2	4	3

Table 16. Health Promotion Program Evaluation

Indicators	**Yes (%)**	**No (%)**	**Total plans (%)**
Participation rates	9 (69.2)	4 (30.8)	13 (100)
Cost-effectiveness	6 (46.2)	7 (53.8)	13 (100)
Member Satisfaction	11 (84.6)	2 (15.4)	13 (100)

The focus groups were held for small business employers located in South Carolina, between July and October 1999. Key informant interviews were conducted via telephone with small business employers who were unable to attend the focus groups. The focus groups and key informant interviews were conducted to achieve the following objectives:

1) to assist the researchers in interpreting the results of other research related to small businesses= access to health insurance;

2) to gauge the prevalence of low take-up rates among small businesses;

3) to determine the availability of HMO coverage for participating small businesses;

4) to obtain opinions and recommendations regarding innovations and improvements in the small business insurance market that would benefit small businesses; and

5) to use the findings to develop a research agenda focusing on the issues of importance in the small employer health insurance market.

Community Setting/Environment

Businesses were located in the Midlands of South Carolina which is comprised of Richland, Lexington, Fairfield and Newberry Counties, and has an estimated population of 545,000 persons, residing in urban, suburban and rural areas. Major employer categories include state and federal government, educational institutions, health care providers, construction, manufacturing, retail trade and service industries. The unemployment rate (as a

military, health care providers, educational institutions, construction, wholesale and retail trade and service. The unemployment rate (as a percentage of the labor force) in Sumter County has been decreasing over the past year, and in June 1999 the rate was 4.9%.

Participants and Respondents

There were a total of sixty-seven (67) small business representatives who participated in focus groups or key informant interviews for this portion of the study. Participants for three of the focus groups were selected with the assistance of the Greater Columbia Chamber of Commerce and the Greater Sumter Chamber of Commerce. Participants for the small business focus groups, with less than 50 employees and between 50 and 100 employees, were selected from the membership list of the Greater Columbia Chamber of Commerce. With the assistance of the Chamber staff, invitation letters were mailed to approximately 25 potential attendees for each focus group. Participants for the Sumter focus group were selected from the membership list of the Greater Sumter Chamber of Commerce. With the assistance of the chamber staff, 20 small business employers were invited to attend.

The invitees to the fourth focus groups were selected from a list of small businesses which were known to have uninsured employees. The researchers received the listing of employers from a community health center and hospital, which provided health care services to employees of these businesses on a free or sliding scale basis. Fourteen (14) small businesses were invited.

Key informant interviews were conducted to follow up with those small businesses, which were unable to participate in the focus groups. Twenty-three (23) interviews were conducted in mid-September.

The industry types for the sixty-seven (67) small businesses were: service (27), wholesale trade (4), financial/real estate/insurance (8), retail trade (1), health care providers (4), and manufacturing (23). There was a mix of company size, as measured by the number of employees. Of those which offered health insurance, the majority (26) of the small businesses had between 3 and 25 employees. Thirteen (13) small businesses had between 25 and 50 employees, and twelve (12) had between 50 and 100 employees. See Table 17. One small business had multiple locations within South Carolina and two were multi-state with a home office in another state.

Table 17. Focus Group Participants by Number of Employees Whose Firms Offer Health Insurance

Employee Number Categories	**Number of Companies (%)**
< 25 Employees	26 (42.4)
25-49	13 (30.3)
50-100	12 (27.3)
Total	51 (100.0)

health insurance, eleven (11) offered indemnity, sixteen (16) offered Preferred Provider Organization (PPO) coverage, and twenty-four (24) offered Health Maintenance Organization (HMO) coverage. (See Appendix D) Of the sixteen small businesses, that were not currently offering health insurance, eight were actively seeking health insurance coverage. One small business was attempting to join an existing group in order to make the premiums affordable. Focus participants responded to a series of questions to include: 1) Who pays the health insurance premiums and at what percentage? 2) Why they offered health insurance benefits? 3) Did they have adequate access to health insurance coverage, particularly HMO coverage? 4) What was the take-up rate in their respective businesses? and 5) What recommendations would they make to improve the small business insurance market?

Who Pays the Premiums?

The proportion of the premium, that was being paid by the employer, for employee only coverage varied from 100% to 50%. Thirty-five (35) employers paid 100% of the employee only premium. The other companies paid 90%, 80%, 75%, 60% or 50% of the premium. In most small businesses (39), the employee paid for dependent coverage. One small business paid 50% of the premium for dependent coverage, one paid 75% of the premium for dependent coverage, and another small business paid 100% of the premium for dependent coverage.

Why Offer Health Insurance?

business was not able to hire a qualified applicant because she chose another employer, that offered health insurance. Other respondents indicated that offering health insurance was the right thing to do/everyone needs health insurance and that employees want and expect it. And, one participant said that health insurance would help keep employees healthy, especially older employees who have greater health care needs.

Do You Have Adequate Access To Health Insurance and HMO Coverage?

No participant expressed a concern that their small business lacked access to health insurance or HMO coverage. Several respondents indicated that their companies had a choice of insurance products from which to choose. The primary concern expressed by respondents related to the affordability of health insurance premiums for their companies and their employees. A second concern related to the potential bias that health insurance brokers and sales persons have against smaller accounts because of the lower sales commission and higher costs associated with servicing a small business.

What Is the Take-Up Rate Within Your Company?

No participant indicated that employees did not accept employee only coverage in those small businesses that paid 100% of the premium. In those small businesses where the employees contributed to the cost of the premium for employee only coverage and also had to pay 100% of dependent coverage, employees were less likely to enroll. Those employees choosing not to enroll tended to have other forms of health insurance coverage, such as

pre-existing health conditions. Another employer said that younger employees often did not feel that they needed health insurance and therefore would not pay their portion of the premium. The following are some of the quotes, which were received in response to this question:

- X These people have never had coverage before. They use the ER and pay as they go.
- X They think, >Why should I pay for it now?
- X Even with insurance, they must pay a co-payment when they go to the doctor.
- X My employees are able to get free care if they say that they do not have health insurance when they go to the doctor.
- X As long as we (the nation) provide free care, why do we need health insurance?
- X They (young people) do not enroll because they think they do not need it.

In each of the focus groups, researchers asked employers about their low-income employees whose children might be eligible for the state's Child Health Insurance Plan (CHIP). Many participants indicated that there may be potentially eligible employees in their company, but no one had knowledge of the program. These comments were especially interesting in light of the CHIP program's successful enrollment of over 100,000 children in South Carolina. There is a tremendous opportunity to provide information and education

With the exception of the first recommendation, the following recommendations are not presented in any specific priority order. The method of data gathering, i.e. multiple focus groups and key informant interviews, did not allow for a ranking process.

- X Overwhelmingly, employers expressed a concern about the future cost of health insurance premiums for small businesses and their employees. Additionally, many respondents felt that an increasing number of low-wage earners would choose not to have health insurance because of increasing premiums and deductibles and co-payments.
- X Small businesses want to continue to have choices. Competition among health insurance carriers helps to keep costs down and helps employers to maintain/enhance benefits. They also want to have flexibility to adjust benefits, co-payments, and deductibles.
- X Employees of small businesses need education (from the health insurance company/HMO) regarding their benefits, how to use them, and their responsibility to be wise purchasers of health care services.
- X Small businesses need more information about federal and state health insurance laws and regulations.
- X Small businesses often do not receive the level of customer service from the insurer/HMO that larger employers receive.

insurer from sharing claims information with the employer, even when the employee asks for assistance from the employer.

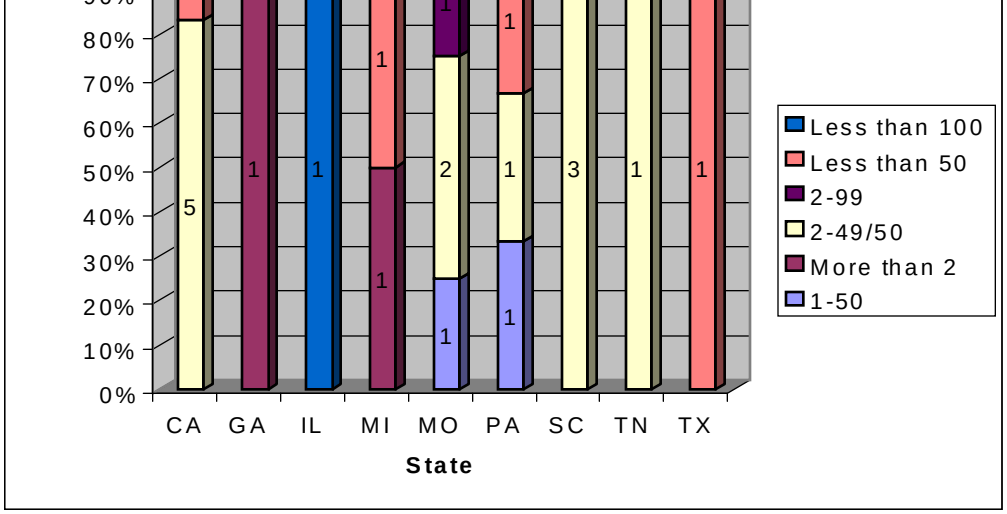
X Small employers want more health promotion and wellness programs for their employees.

states= definition and HMOs= definition were found. See Table 18 and Figure 12. In Missouri, out of 4 responding HMOs, 3 defined a small business as an employer with 1-50 employees, and one HMO defined a small business as 2-99 employees, while the state of Missouri defined it as 3-25 employees. The state of California, from which six HMOs responded, had all of them defining a small business as one with less than 50 employees, although the state regulation defined it as 3-25 employees.

Table 18. Company Definition of Small business by State (n=22)

	A	A	L	I	O	A	C	N	X	J
1-50										
2										
2-49/50										
2-99										
50										
100										
otal										

* Federal Government defines small employer as 3 through 25 as same as CA and MO.



PA, and MI don=t have any small employer legislation.

Figure 12. Company Definition of Small Business by State

The discrepancy in itself is surprising considering that small business regulations are binding upon insurance companies. This raises important questions regarding the role of regulation in bringing about desired socio-economic change. Apart from larger issues of compliance, the curious nature of the discrepancy raises the issue of the state's rationale in

benefits, as reported by all HMO plans that responded to the survey.

Guaranteed renewal provisions

The survey indicated that the non-renewal rate at the initiative of the HMO, (apart from reasons of non-payment of premium) was negligible, ranging from 1-22 policies in the last year for the ten states surveyed. The guaranteed renewal provisions appear to be effective in limiting involuntary terminations of small business health insurance.

Issues of real access and cost of HMO plans

Access. All states (except Michigan and Pennsylvania whose statutes were not available for review) require small employer carriers, as a condition of doing business in the state, to actively market each of its health benefit plans to all small employers in the state with full information on each plan, shall market the basic and standard plans with the same resources and methods as other health plans, and, that a small employer carrier may not vicariously violate any of the adverse selection practices through commercial arrangements with insurance producers or agents to selectively enroll small employers for commercial advantage. Yet, the small employer focus group participants indicated that often the marketing agents do not disclose information about low cost plans due to monetary considerations (commissions being paid as a percentage of volume of business generated). This raises an important issue of how far regulation can really ensure the fair marketing of low cost plans by insurance agents, which is the key to improving small business access to

insurance for their workers. This is especially so for those small businesses that have less than 25 employees and have a disproportionate share of low-wage earning employees. This is occurring in spite of ongoing state and federal efforts to address this problem through legislation. Gable, et al (1997) found similar results even though states have been consistent in adopting regulations that limit ratings practice use. These state and federal efforts to address the problem are occurring even as the number of uninsured Americans continues to increase, with increasing numbers of the working poor being added to the rolls. These may be full-time workers in small or medium size businesses, part-time workers, or temporary workers without benefits. At the same time, findings indicate that low-wage earners are less likely to be eligible for health benefits and less likely to take them up (take-up rate). When they do take up health benefits, they are more likely to pay a greater share of the premium for single and family coverage and have a benefit package that requires a greater sharing of expenses in the form of higher deductibles and co-payments, as well as restricted benefits.

This project was devoted to examining the supply side of the health benefit equation. Each state's laws have been reviewed in depth to determine the different approaches of state regulation to aid small businesses in acquiring health insurance for their employees. Federal model legislation provided a template or framework for structuring legislation at the state level. It is clear from the review that each state is unique in its structuring of health insurance legislation for the small employer market.

limited information regarding employee cost-sharing. The HMO survey attempts to explore the small business health insurance market by attempting to understand marketing issue. The survey was used to examine different types of services available to small businesses including disease prevention and health promotion activities, special product designs for the small business market, and small business market issues as perceived by the health insurance provider. One of the problems of ascertaining information from HMOs is the poor response rate, even after repeated contact. Colleagues from other institutions report similar problems.

Survey findings covering the 50 most popular plans offered by these HMOs are presented in this report. An integrated review of these findings in conjunction with the focus group findings and document review, suggests that regulation at best, has been only partly successful in achieving its goal, which is consistent with earlier studies (Nichols et. al, 1998). This study has shown that discrepancies between explicit legal provisions and practice do exist, such as in the definition of a small business. This also suggests the need to research in depth the extent to which regulation is actually being implemented.

Mandated benefits appears to be implemented by the HMOs which is illustrated by universal offering of maternity and mental health benefits in line with state regulations.

Other regulations such as mandates for fair marketing of low cost plans, are being implicitly breached. Built-in adverse marketing incentives mitigate against fair marketing of

health insurance plan, specifically an HMO option. In addition, several questions from the employer perspective need to be addressed: 1) What are the barriers to offering a plan to all employees, as opposed to only high-wage, full-time employees? 2) Have the laws in the different states had an impact on a small business's ability to provide a health plan to employees? 3) What do small businesses actually know about state insurance regulation? 4) What is the impact of expanding Medicaid and CHIP programs to their employees?

A review of the current literature indicates that those employees in companies with many low-wage earners, especially found in small businesses, have a significant number of employees that do not take up insurance even when it is offered to them. The take-up rate (employee demand) and the attending issues have not been examined from the employee perspective, although an occasional article proposes an explanation.

Additional research is needed focusing on those employees that do not accept the health plan offered by their employers. Specific questions that need to be addressed are: 1) What are the reasons (barriers) for not taking up the health insurance benefit? 2) What changes are needed to enable the employee to use the health insurance benefits offered? 3) What benefit options are most desired? 4) How do employees view HMO products and services? 5) Are employees aware of expanded Medicaid and CHIP programs in their states and do they view them as a possible alternative to employer-sponsored health insurance?

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